STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6016885		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G:	(X3) DATE SURVEY	(X3) DATE SURVEY COMPLETED	
				G	С		
		B. WING		09/18/2015	•		
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	, STATE, ZIP CODE			
MANOR	COURT OF CARBON	DALE	VESTRIDGE IDALE, IL 6				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE		
S 000	Initial Comments		S 000			_	
manyer ilinox above .	Complaint# 155494 Complaint# 155496		A (V) mink i demonstration of the control of the co				
S9999	Final Observations		S9999				
	Nursing and Person b) The facility shall pand services to attal practicable physical well-being of the reseach resident's complan. Adequate and care and personal cresident to meet the care needs of the resonal care needs of the resonance needs of t	eneral Requirements for					
i i a c f	care shall include, at and shall be practice seven-day-a-week ba 1) Medications, inclu ntravenous and intra administered. 3) Objective observa esident's condition, emotional changes, a determining care req urther medical evalu			Attachment A Statement of Licensure Vic	olations		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/12/15

XT0511

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		·	A. BUILDING			0	
		IL6016885	B. WING		j .	18/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
MANOR	COURT OF CARBON	DALE	ESTRIDGE				
	,		DALE, IL 62	· · · · · · · · · · · · · · · · · · ·			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 1	S9999				
	resident's medical r	ecord.		TOTAL			
	Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.						
	These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer Schedule II pain medication routinely as ordered and failed to administer an antibiotic for 7 days after the initial order for 2 of 4 residents reviewed for medication in the sample of 7. This failure resulted in R3 enduring pain of at least a pain level of 8 on a 1-10 scale for 3 days,and being unable to maintain normal routine of being up in wheelchair during the day and taking meals in dining room, due to increased levels of pain.						
	admitted to the facili diagnoses appears of Administration Reconflower Cerebral Palsy, Genfultiple Sites, Pain in Osteoporosis, Histor R3's Care Plan initial pain as a problem for Cerebral Palsy and Condicates routine pair The Goal for this Propave decreased Risk next review Approacts and the Goal for 10/10/20 prescription as order	s Profile Sheet, R3 was ty on 10/8/2014. A list of R3's on R3's MAR (Medication rd) for 9/2015 and includes eralized Osteoarthritis at n joint-lower leg, y of Sprain/Strain of neck. ted on 10/08/2014, identifies r R3 due to diagnoses of Generalized Arthritis and n mediations are in place. To blem Area listed as: "Will to of unmanaged pain through thes for pain management of 14 include: Administer ed, 'Monitor for breakthrough omptly, R3 prefers to be					

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XT0511

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING:				
<u> </u>		IL6016885	B. WING			C /18/2015
NAME O	F PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MANOF	R COURT OF CARBON	DALE	/ESTRIDGE DALE, IL 6:			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From page	ge 2	S9999			
	awakened during th R3' Physician's Ordan order for Percoco 7.5milligrams/325 ma.m., 6 a.m., 12 p.m.  On 9/15/2015 at 11: room in wheelchair. observed in the dinir midday meal. R3 wa 7:35 a.m. in the dinir 9/17/2015 R3 sitting in conversation with  On 9/15/2015 at 12 Director of Nursing, 6	e night for pain medication. er Sheet for 9/2015, includes et (oxycodone/acetaminophen iilligrams) every 6 hours at 12 i., and 6 p.m.  36 R3 was sitting in her On this same day R3 was ng room in wheelchair for the es observed on 9/16/2015 at ng room for breakfast. On g in wheelchair and engaged				
	R3 missing 6 doses 9/2015 indicates that medication from 9/7/9/8/2015 at 4:16 p.m on the MAR for the d Not Administered: Dr Administered: new so	of Percocet. R3's MAR for R3 did not receive the 2015 at 6:00 a.m. through a. The reasons documented oses not being given are, ug Unavailable, and Not			:	
	Nurse, that she gave R3's pain was mild at not work on 9/8/2015 and noted that stayed On 9/17/2015 at 11:1 time when the Percoshe asked to stay in the stayed of the stay in the stayed of the stay in the stayed of	R3 Tylenol on 9/7/2015 and that time. E6 stated E6 did but returned on 9/9/2015 d in bed due to discomfort. 0 p.m., R3 stated during the cet was not available that bed due to increased pain in that she prefers to be up in				
	p.m. states "Residen stating her back hurts	R3 dated 9/8/02015 at 3:14 t was in tears this a.m. so bad. Resident screamed l. Resident did not eat				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6016885		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
			1			_
		B. WING			С	
		1 1200 100003	1 3		09/	18/2015
NAME (	OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
MANC	R COURT OF CARBON	2940 W V	VESTRIDGE	PLACE		
MAIN	ACCOUNT OF CARBON		DALE, IL 62			
(X4) IE	SUMMARY STA	TEMENT OF DEFICIENCIES			~	
PREF	X (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX (	PROVIDER'S PLAN OF CORRECTION SHOUL		(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
			771Adam com	DEFICIENCY)		
S999	9 Continued From pa	ge 3	S9999			
	breakfast and rofus	ed to get up for lunch. Lunch	71110000000000000000000000000000000000			
	was fed to her hy C	NA (Certified Nurses Aid)				
	Multiple phone colle	made to and faxes made to	and the state of t			
	Z5's (R3' physician	\ affice "	- Andrewson			3
	203 (NO physician)	) onice	and the second s			
	A Progress Note dat	ted 9/9/2015 for R3 at 2:26	Title of the second			
	p.m. that R3 staved	in bed related to pain.	1			
	New York Control of the Control of t		To the same of the			
	A Progress Note da	ited 12:21 p.m. states "Writer	TO THE PARTY OF TH			
	called Z5's office and	d spoke with nurse. Writer	7			
	stated resident (R3)	had missed 6 doses				
	Percocet related to r	no current script on file at				
	pharmacy ( 9/7/2015	59/8/2015). Received a				
	dose on 9/8/2015 at 1615 (4:15 p.m.) per progress note with routine schedule resuming.					
	Resident (R3) has re	eceived 6 doses of prn ( as				
	needed) Tylenol and	utilizing hot packs since				
	9/7/2015 as of note.	resident given routine	77.00			
	Percocet at 11:23 an	d rated pain at 10/10 with hot				
	applied. Per Z5's nur	se report, Z5 stated " to	***************************************			
	continue as needed	Tylenol and hot packs as	B.F. A.			
	previously done." " It	will take a few days for pain				
	to subside and return	to her normal". No new				
	orders at this time. W	/riter then called back to			ĺ	
	inquire on parameter	s for hot packs, waiting on			1	- 1
	call back. Will continu	ue to monitor."	- i + i + i + i + i + i + i + i + i + i			
	Pain assessments	1 10 00010 600 500				l
	recorded Pala MAD 4	n 1-10 scale for R3 for were or each shift beginning with	P.O. D. D. C.			
	day shift as follows:	OF each shift beginning with				
	9/8/2015-9,9,8) (9/9/2	2015 5 7 9 \				
	(9/10/2015-10,6,8).	2010-0,7,6,)				ļ
	(=. 10,2010 10,0,0).	Transmission.			The state of the s	
		Vivi	Î			
	2. R2 s MDS (Minimi	um Data Set) of 8/6/2016			100	-
1	list of diagnoses inclu-	des. Heart Failure				ł
	Coronary Artery Disea	ase, and Non-Alzheimer's	· wasans.com		3	
	Dementia. Document	tation on R2's Physician's	1			
	Order Sheet dated 8/1	17/2015 states "Resident	an part to the same			l
1	(R2) on Hospice, com	fort measures only. "				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING	7			
		IL6016885	B. WING		C 09/18/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
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MANUK	COURT OF CARBONI	CARBON	DALE, IL 6	2901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTION (EACH CONTRACT)	D BE	(X5) COMPLETE DATE	
S9999	Continued From page	_	S9999				
		R2 dated 9/01/2015 at 6:33 at R2 fell in his room and	PPY SIST VISITABLE				
7 7 7 1	sustained a laceration	on to the right ring finger and					
	call placed to Z4, (R A Progress Note for	R3 dated 9/03/2015 at 2:31					
		Z3 (Hospice Nurse) states					
	contacted Z4 and re	hand are swollen and red, eceived new order for Bactrim					
	DS 1 tablet twice da			TORSTON			
	R2's Medication Administration Record for 9/2015 indicates that R2 did not start receiving Bactrim DS until 9/10/2015. On 9/16/2015 at 9:17 a.m., E3, Assistant Director of Nursing, verified that an order had been received for the Bactrim DS for R2 on 9/3/2015., that the order did not get transcribed and was not						
· ·							
	started until 7 days I	ater on 9/10/2015.					
and other states and the		01 p.m., when asked about 22s right ring finger between					
	9/7/2015 and 9/10/2	015, E8, LPN ( Licensed					
		ed that initially R2 's finger pred and with a little edema					
	but did not not seem unusually warm and that the appearance did not seem to change much during that time, "it didn't get better and it didn't get worse." E8 further stated that now it seems to be						
	improving, but slowly On 9/17/2015 at 2:07	/. 7 p.m., E11, Registered					
	Nurse, stated that between 9/3/2015 and 9/10/2015 R2's right ring finger appeared red, a little inflamed, it didn't get any worse, but now it is improving " E11 further stated that he checked R2 multiple times for pain and R2 never complained of pain.						
					MICPosan L		
					1		
10 mm	A Physician-Monthly	Visit for R2 dated 9/11/2015			Male		
		"Erythema, warmth, and finger consistent with					
	cellulitis."						
	On 9/15/2015 at 9:10 a.m., R2 's finger appeared reddened, slightly swollen, and the position						

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STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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		B 111110		C		
IL6016885		B. WING		09/18/2015		
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		CARBON	IDALE, IL 6	2901		
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